Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Healthcare South Dallas

Respondent Name
XL Insurance America Inc

MFDR Tracking Number
M4-14-1389-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 21, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The initial evaluation (99204) is with Office Disability Guidelines. A treating doctor must evaluate the patient on the initial visit to determine diagnosis. I have included the Treating Doctors' examination from that visit. The 73 billed (99080) is a requirement of Texas Division of Insurance… Therefore, these denials are incorrect and should be paid in full immediately."

Amount in Dispute: $406.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 31, 2013 August 6, 2013	99204, 99080 97001	$406.50	$15.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §129.5 sets out guidelines for Work Status Reports.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing

Issues

1. Was the claim submitted with appropriate modifier?
2. Were the requirements of work status report met?

3. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service, 99204, as, 4 – "The procedure code is inconsistent with the modifier used or a required modifier is missing" 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. The American Medical Association (AMA) CPT code description for 99204 is:

   > Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; a comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family

   The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare policy. It describes the documentation requirements for the service in dispute. Review of the documentation finds the following:

   - Documentation of the Comprehensive History
     - History of Present Illness (HPI) consists of at least four elements of the HPI or the status of at least one chronic or inactive condition. Documentation found listed five elements, thus meeting this component.
     - Review of Systems (ROS) inquires about the system (s) directly related to the problem(s) plus additional body systems. At least ten organ systems must be reviewed. Documentation found listed one system, this component was not met.
     - Past Family, and/or Social History (PFSH) requires a review of two or all history areas, at least one specific item from each history areas to be documented. The documentation found listed one area. This component was not met.
   - Documentation of a Comprehensive Examination:
     - Requires at least nine organ systems to be documented, with at least two elements listed per system. The documentation found listed three body areas: head, cervical and lumbar. Elements listed for cervical and lumbar were musculoskeletal and neurological. This component was not met.

   The use of the 25 modifier is defined as, "A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service)." As stated above the submitted documentation does not satisfy the relevant criteria for the 99204 therefore, the 25 modifier is not substantiated. The carrier's denial is supported. No payment can be recommended.

2. 28 Texas Administrative Code §129.5 (b) states in pertinent part, "The doctor shall file a Work Status Report in the form and manner prescribed by the Commission." Review of the submitted documentation finds provisions of work status reporting was met. The submitted charge was $15.00, this amount is recommended.

3. The carrier denied the CPT code 97001 for date of service August 6, 2013 as, 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing. Per MLN Matters Number: MM8166 Effective Date: April 1, 2013, Outpatient Therapy Functional Reporting Non-Compliance Alerts, "Effective for therapy claims with dates of service on or after January 1, 2013 and processed on and after April 1, 2013, through June 30, 2013, contractors will alert providers, who submit claims containing any of the following CPT evaluation/re-evaluation therapy codes 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004 without functional information, that these codes require functional G-code(s) and appropriate severity/complexity modifier (s), and effective July 1, 2013, claims that do not include required functional reporting information will be returned or rejected. The following CARC and RARC will be used as the alert message: • CARC 246 - "This non-payable code is for required reporting only." And • RARC N566 - "Alert: This procedure code requires functional reporting. Future claims containing this procedure code must include an applicable non-payable code and appropriate modifiers for the claim to be processed. When CPT

codes 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 97001, 97002, 97003, or 97004 are submitted without the nonpayable HCPCS codes G8978 to G8999, G9158 to G9176, or G9186 and the appropriate modifier (CH – CN). Beginning July 1, 2013 • Beginning July 1, 2013, your claims will be returned or rejected using a new RA message when you do not comply with these reporting requirements." 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" The submitted claim with this dispute did not contain the GP modifier. The carrier's denial is supported. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $15.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $15.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		October 9, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.